



SANDRA SHEWRY
Director

State of California—Health and Human Services Agency
Department of Health Services



ARNOLD SCHWARZENEGGER
Governor

Dear Applicant:

Thank you for your recent inquiry regarding participation in the Medi-Cal program. Please complete the enclosed Medi-Cal provider enrollment application package and return it to:

California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413

PLEASE NOTE: Effective January 1, 2004, new law governing enrollment of providers in the Medi-Cal program resulted in a process for the Department of Health Services (Department) to more thoroughly review applicants applying to participate in the Medi-Cal program and established a new provisional provider status. In addition, it resulted in revisions to the provider enrollment application forms.

Please read all the instructions included in the application package carefully and complete each item requested. Incomplete application packages will be returned. Due to the volume of applications received, program staff are unable to reply to a request for the status of an application in process. Therefore, please allow for the 180 days stipulated in regulations for processing your application prior to contacting the Department regarding the status of your application. Information about the completion of enrollment forms is located on the Medi-Cal Web site at www.medi-cal.ca.gov.

It is your responsibility to report to the Department any modifications to information previously submitted within 35 days of the change. Most changes may be reported on a *Medi-Cal Supplemental Changes* (DHS 6209, revised 7/04) form. However, if you are reporting a change of ownership of 50 percent or more, or a change of business address, you must complete a new application package.

Enrollment forms are available at www.medi-cal.ca.gov or by contacting the Telephone Service Center (TSC) at 1-800-541-5555. For more information about the forms and the regulatory requirements for participation in the Medi-Cal program, please visit our Web site at www.medi-cal.ca.gov and click the "Provider Enrollment" link. If you have any questions, please submit your inquiry in writing to the above address

Provider Enrollment Branch
Payment Systems Division

Enclosures

(Revised 10/04)

INSTRUCTIONS FOR COMPLETION OF THE MEDI-CAL TRANSPORTATION PROVIDER APPLICATION

DO NOT USE correction tape, white out, or highlighter pen or ink of a similar type on this form.

This form is an application for enrollment or continued enrollment as a provider in the Medi-Cal program. Applicants and providers must also provide additional information and documentation. Applicants may be subject to an on-site inspection prior to enrollment. Applicants or providers may be subject to unannounced visits prior to enrollment or approval for continued enrollment in the program. In addition to the application and requested documentation, a Medi-Cal Disclosure Statement (DHS 6207) and a Medi-Cal Provider Agreement (DHS 6208) must also be completed for enrollment or continued enrollment. Additional information can be found at the following Medi-Cal web site, Provider Enrollment link: www.medi-cal.ca.gov.

Omission of any information or documentation on this form or the failure to sign any of these documents may result in any of the denial actions identified in Title 22, California Code of Regulations (CCR), Section 51000.50.

Enrollment action requested (check all that apply). Enter the date you are completing the application.

“New provider”—the applicant is not currently enrolled in the Medi-Cal program and would like a Medi-Cal provider number issued.

For any of the following changes checked, please provide a current Medi-Cal Provider number:

“Change of business address”—the applicant is currently enrolled in the Medi-Cal program and is requesting to relocate to a new business address and vacate the old location.

“Additional business address”—the applicant is currently enrolled in the Medi-Cal program and is requesting a Medi-Cal provider number for an additional business location.

“Change of ownership”—there is a change of ownership as defined in Title 22, CCR, Section 51000.6.

“Sale of assets (50 percent or more)” —fifty (50) percent or more of the assets owned by the corporation, at the location for which a provider number has been issued, are sold or transferred.

“New Taxpayer ID number”—a new Taxpayer Identification Number (TIN) is issued by the IRS.

“Cumulative change of 50 percent or more in ownership or control”—there is a cumulative change of 50 percent or more in the person(s) with an ownership or control interest, as defined in Title 22, CCR, Section 51000.15, since the information provided in the last complete application package that was approved for enrollment.

“Add or replace medical transportation vehicle”—the applicant is currently enrolled in the Medi-Cal program and is requesting to add another medical transportation vehicle or replace an existing medical transportation vehicle.

“Continued enrollment”—the applicant is currently enrolled as a Medi-Cal provider and has been requested by the Department to apply for continued enrollment in the Medi-Cal program. Do not check this box unless you have received notification from the Department, pursuant to Title 22, CCR, Section 51000.55. List current Medi-Cal provider number(s).

Check the box labeled “I intend to use my current...” if you intend to use your current provider number to bill for services delivered at this location while this application request is pending. This action places the provider on provisional provider status, pursuant to Title 22, CCR, Section 51000.51(b).

“Type of entity”—check the box which applies to your business structure. Your corporate status will be verified using the corporate number and state in which incorporated. If a partnership, please attach a legible copy of the partnership agreement.

“Type of transportation”—check all that apply.

“Specific mode of transportation”—check all that apply.

1. “Legal name”—the name listed with the Internal Revenue Service (IRS).
2. “Business name”—the name of the applicant or provider if different from that named in number 1. If this is a fictitious business name, provide the Fictitious Business Name Statement/Permit number and effective date. Attach a legible copy of the recorded/stamped Fictitious Business Name Statement to the application.
3. “Business telephone number”—primary business telephone number used at the business address. A beeper number, cell phone, answering service, pager, facsimile machine, biller or billing service, or answering machine may not be used as the primary business telephone.
4. “Business address”—the actual business location including the street name and number, room or suite number or letter, city, county, state, and nine-digit ZIP code. A post office box or commercial box is not acceptable.
5. “Pay-to address”—the address to which payment will be mailed and should include, as applicable, the post office box number, street number and name, room or suite number or letter, city, state, and nine-digit ZIP code.
6. “Mailing address”—the address at which the applicant or provider wishes to receive general Medi-Cal correspondence, if different from the business address. General Medi-Cal correspondence includes bulletin updates and Provider Manual updates.
7. Enter the Taxpayer Identification Number (TIN) issued by the IRS under the name of the applicant or provider. Attach a legible copy of IRS Form 941, Form 8109-C, Letter 147-C, or Form SS-4 (Confirmation Notification).
8. If the business is a sole proprietorship not using a TIN, provide the social security number of the sole proprietor. (See Privacy Statement on page 5.)
9. Enter the applicant's or provider's Medicare billing number.
10. “Hours of operation” are business days and hours that the applicant or provider is available for service to Medi-Cal beneficiaries.

11. "Geographic area(s) served"—those areas in which you will be transporting Medi-Cal beneficiaries. Attach a copy of the city/county business license/permit to the application. If the city/county does not require a license/permit, you must attach a letter from that city/county confirming licensing/permit requirement with the application. It is the applicant's or provider's responsibility to verify with the city/county in which transportation services will be provided for vehicle and driver's permits. If you intend to conduct business in either the City of Los Angeles or the City of San Diego, you must apply for their vehicle and driver's permits. For more information, contact either the City of Los Angeles Department of Transportation or the San Diego Metropolitan Transit Development Board.
12. Provide the following information and attach legible copies if applicable:
- Ambulance:
- ☐ Certificate number issued by the California Highway Patrol (CHP)—attach a legible copy of the certificate to the application.
 - ☐ Issue date
 - ☐ Vehicle Identification Number (VIN) of each vehicle that will be used to transport beneficiaries
 - ☐ Make and model of vehicle
 - ☐ Year of vehicle
 - ☐ License plate number of vehicle
 - ☐ EMS verification
- Driver information:
- ☐ Full legal name of driver
 - ☐ Driver's license number
 - ☐ Ambulance Driver Certificate number
13. Provide the following information and attach legible copies if applicable:
- ☐ Certificate number issued by the Federal Aviation Administration (FAA)—attach a legible copy of the certificate to the application.
 - ☐ Name and address where the aircraft is hangared—This statement must also be on your company letterhead and be attached to the application.
 - ☐ EMS verification
- Pilot information:
- ☐ Full legal name of pilot
 - ☐ Pilot's license number—the number issued by the FAA on the pilot's license of the individual named
14. Provide the following information and attach legible copies if applicable:
- Litter and/or wheelchair van:
- ☐ VIN of each vehicle that will be used to transport beneficiaries
 - ☐ Photographs of vehicle (i.e., view of inside, back exit door, side exit door, and view of business name)
 - ☐ Make and model of vehicle
 - ☐ Year of vehicle
 - ☐ License plate number of vehicle
- Driver:
- ☐ Full legal name of driver
 - ☐ Driver's license number
15. "Printed name of provider"—print first, middle, and last name of the provider as the sole proprietor, partner, corporate officer, or government official when applying to the Department for enrollment or continued enrollment as a provider in the Medi-Cal program.
16. Check (✓) the gender of the individual named in number 15.
17. Enter the driver's license or state-issued identification number and state of issuance of the individual named in number 15. Attach a legible copy.
18. Enter the date of birth of the individual named in number 15.
19. Provide the social security number of individual named in number 15. (Optional, see Privacy Statement on page 5)
20. An original signature is required of the individual named in number 15. Enter the title of the person signing the application; include city, state, and date where and when the application was signed.
21. Applicants and providers licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, the Osteopathic Initiative Act, or the Chiropractic Initiative Act ARE NOT REQUIRED to have this form notarized. If it must be notarized, the Certificate of Acknowledgement signed by the Notary Public must be in the form specified in Section 1189 of the Civil Code.
- ✓ Remember to attach a legible copy of current documentation, if applicable:
- | | |
|---|--|
| <input type="checkbox"/> Fictitious Business Name Statement/Permit | <input type="checkbox"/> DMV driving history printout for each driver |
| <input type="checkbox"/> TIN verification | <input type="checkbox"/> City/county business license/certificate |
| <input type="checkbox"/> CHP certificates (301 and 360A) | <input type="checkbox"/> Driver's license or state-issued identification card of person signing the application |
| <input type="checkbox"/> DMV commercial vehicle registration | <input type="checkbox"/> Verification of Emergency Medical Services (EMS) |
| <input type="checkbox"/> Proof of insurance | <input type="checkbox"/> Photographs of litter and/or wheelchair van (i.e., view of inside, back exit door, side exit door, and view of business name) |
| <input type="checkbox"/> Brake and Lamp Certificate | <input type="checkbox"/> Signed Medi-Cal Provider Agreement (DHS 6208) |
| <input type="checkbox"/> FAA certificate | <input type="checkbox"/> Signed Medi-Cal Disclosure Statement (DHS 6207) |
| <input type="checkbox"/> FAA Pilot's License for each pilot | |
| <input type="checkbox"/> Driver's license for each driver | |
| <input type="checkbox"/> Certificates for first aid and CPR for each driver | |
| <input type="checkbox"/> DMV DL-51 form signed by a physician for each driver | |
| <input type="checkbox"/> Standard pre-employment drug and alcohol tests lab results for each driver | |



MEDI-CAL TRANSPORTATION PROVIDER APPLICATION

Important:

- Read *all* instructions before completing the application.
- Type or print clearly, in ink.
- If you must make corrections, please line through, date, and initial in ink.
- Return completed forms to: California Department of Health Services
Provider Enrollment Branch
MS 4704
P.O. Box 997413
Sacramento, CA 95899-7413
(916) 323-1945

FOR STATE USE ONLY

Do not leave any questions, boxes, lines, etc. blank. Enter N/A if not applicable to you.

Enrollment action requested (check all that apply)

☐ New provider

Date

For any of the following actions, include current Medi-Cal provider number: _____

☐ Additional business address

☐ Change of ownership

☐ Change of business address

☐ Sale of assets (50 percent or more)

☐ New Taxpayer ID number

☐ Cumulative change of 50 percent or more in ownership or control

☐ Add or replace medical transportation vehicle

☐ Continued enrollment (Do not check this box unless you have been requested by the Department to apply for continued enrollment in the Medi-Cal program pursuant to Title 22, CCR, Section 51000.55.)

☐ I intend to use my current Medi-Cal provider number to bill for services delivered at this location while this application request is pending. I understand that I will be on provisional provider status during this time, pursuant to Title 22, CCR, Section 51000.51(b).

Type of entity (check one)

☐ Sole proprietor

☐ Corporation:

Corporate number: _____

State incorporated: _____

☐ Partnership

☐ Limited liability company:

Corporate number: _____

State incorporated: _____

☐ Government

☐ Nonprofit

Type of nonprofit: _____

☐ Other: _____

Type of transportation

☐ Emergency

☐ Both

☐ Nonemergency

Specific mode of transportation (check all that apply)

☐ Helicopter

☐ Wheelchair van

☐ Litter van

☐ Fixed-wing

☐ Both wheelchair and litter van

☐ Ambulance

1. Legal name of applicant or provider (as listed with the IRS)

2. Business name, if different

3. Business telephone number

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Is this a fictitious business name?

☐ Yes

☐ No

If yes, list the Fictitious Business Name Statement/Permit number

Effective date

(Attach a legible copy of the recorded/stamped Fictitious Business Name Statement/Permit.)

4. Business address (number, street)

City

County

State

Nine-digit ZIP code

5. Pay-to address (number, street, P.O. Box number)

City

State

Nine-digit ZIP code

6. Mailing address (number, street, P.O. Box number)

City

State

Nine-digit ZIP code

7. Taxpayer Identification Number (TIN)
(attach a legible copy of the IRS form)

8. Social security number—if sole proprietor not using a TIN, you must disclose this number
(See Privacy Statement on page 5.)

9. Medicare billing number

10. Business days and hours of operation:

Days: _____

Hours: _____

11. Geographic area(s) served (list county(ies), including each city served, and attach copy(ies) of business tax permit(s)/license(s))

12. Ambulance and Driver Information—see *instructions* (attach separate sheet, if necessary)

Ambulance Information

CHP Certificate Number	Issue Date	Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License Number

Ensure legible copies of the following documents for each ambulance are attached to the application:

☐ CHP 301 certificate ☐ EMS Certificate, local ☐ CHP 360A Ambulance license

Driver Information

Name	California Driver's License Number

13. Aircraft and Pilot Information—see *instructions* (attach a separate sheet, if necessary)

Aircraft Information

FAA Certificate Number	Name and Address Where Aircraft is Hangared

Ensure a legible copy of the following document for each aircraft is attached to the application:

☐ FAA Certificate ☐ EMS Certificate

Pilot Information

Name	Pilot's License Number

Ensure a legible copy of the following document for each pilot is attached to the application:

☐ FAA Pilot's License

14. Litter and/or Wheelchair Van/Driver Information—see *instructions* (attach a separate sheet, if necessary)

Litter and/or Wheelchair Van Information

Vehicle Identification Number(s)	Make and Model of Vehicle	Year	License Number

Ensure legible copies of the following documents for each vehicle are attached to the application:

☐ DMV vehicle registration ☐ Proof of vehicle insurance ☐ Brake and Lamp Certificate ☐ Special vehicle permit (if applicable)

Driver Information

Name	California Driver's License Number

Ensure legible copies of the following documents for each driver are attached to the application:

☐ DMV driving record printout ☐ California Driver's License ☐ DMV DL-51 form signed by a physician
☐ Certificates for first aid and CPR ☐ Special driver permit (if applicable)
☐ Standard pre-employment drug test (which lists the drugs tested for) and alcohol test lab results

Information About Individual Signing This Application

15. Printed name of provider (last)	(first)	(middle)	16. Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
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17. Driver's license or state-issued identification number and state of issuance (attach a legible copy)	18. Date of birth	19. Social security number (<i>Optional</i> —see Privacy Statement below.) _____
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20. I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, the disclosure statement, and provider agreement are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider.

Signature of provider

Title

Executed at: _____, _____ on _____
(City) (State) (Date)

21. Notary Public

**Privacy Statement
(Civil Code Section 1798 et seq.)**

All information requested on the application, the disclosure statement, and the provider agreement is mandatory with the exception of the social security number for any person other than the person or entity for whom an IRS Form 1099 must be provided by the Department pursuant to 26 USC 6041. This information is required by the California Department of Health Services, Payment Systems Division, by the authority of Welfare and Institutions Code Section 14043.2(a). The consequences of not supplying the mandatory information requested are denial of enrollment as a Medi-Cal provider and issuance of the Medi-Cal provider number or denial of continued enrollment as a provider and deactivation of all Medi-Cal provider numbers used by the provider to obtain reimbursement from the Medi-Cal program. The consequence of not supplying the voluntary social security number information requested is delay in the application process while other documentation is used to verify the information supplied. Any information provided will be used to verify eligibility to participate as a provider in the Medi-Cal program. Any information may also be provided to the State Controller's Office, the California Department of Justice, the Department of Consumer Affairs, the Department of Corporations, or other state or local agencies as appropriate, fiscal intermediaries, managed care plans, the Federal Bureau of Investigation, the Internal Revenue Service, Medicare Fiscal Intermediaries, Centers for Medicare and Medicaid Services, Office of the Inspector General, Medicaid, and licensing programs in other states. For more information or access to records containing your personal information maintained by this agency, contact the Chief, Payment Systems Division, (916) 323-1945.